Pulse-less disease of Aortic Arch in Takayasu Aortoarteritis—Percutaneous intervention.

Prof (Dr) Rajesh Vijayvergiya, MD, DM, FSCAI, FACC, FISES
Department of Cardiology
Post Graduate Institute of Medical Education & Research
Chandigarh. INDIA
Disclosure

Speaker name: **Prof (Dr) Rajesh Vijayvergiya**

I have the following potential conflicts of interest to report:

- [ ] Consulting
- [ ] Employment in industry
- [ ] Stockholder of a healthcare company
- [ ] Owner of a healthcare company
- [ ] Other(s)

- [x] I do not have any potential conflict of interest
Introduction

• Takayasu arteritis (TA) is a chronic inflammatory disease of the aorta and its major branches.
• The basic pathology is pan-arteritis that begins from the adventitial layer and spreads upto intimal layer, thereby leading to vascular manifestations.
• Slow progressive occlusion of the arteries in this disease commonly leads to collateral formation which supplies the distal vascular bed.
• The symptoms of cerebral ischemia are most often associated with obstructive lesions in multiple arch vessels.
Introduction

- Symptoms includes fainting spell on standing, altered sensorium, seizures, vertigo or visual disturbance.
- Those with severe ischemic cerebral symptoms needs intervention—percutaneous or surgical.
- Limited published case reports on endovascular treatment for this disease entity.
Case -1

• PD 16 yrs old girl presented in July 2012
  – Chronic headache, dizziness, photophobia-1yr.
  – Decrease vision in left eye- ischemic hypotensive retinopathy.
• On Exam- absent b/l UL and carotid pulsation.
• ESR 43mm in 1st hr., CRP +. On steroid from last 2 months.
CT Scan of Brain & Neck vessels
Rt Brachio-Cephalic artery

Rt BCA 100% occluded

7X150 mm SES in SCA and 7X120 mm SES in CCA. Kissing stenting in BCA.

28th July 2012
Lt Subclavian artery (SCA) Stenting.

2-mths later

Long segment Lt SCA-brachial artery block

8 X 100 and 7 X 100 mm SES

29th Sept 2012
Lt Subclavian artery (SCA) Stenting

- D2 post Lt SCA stenting - pain in left shoulder, local tenderness. USG normal.
- Pain persisted, D9 - rpt USG showed Left subclavian mass ? Hematoma.
- Taken up for check angiogram D12.
Lt SCA pseudo-aneurysm +

SCA pseudo-aneurysm.

9X40 mm Fluency graft stent.
Follow-up

• 3 months of follow-up- headache improved. No dizziness, vision improved.

• CT scan improved perfusion of brain. USG Doppler patent Rt BCA and Left SCA stents. Fundus examination- improved perfusion.
Fundus Examination

Pre-intervention

Post-intervention
4-yrs of follow-up

Total 7 years of clinical follow up
• 30 yrs old male presented in May 2014, with
  – recurrent syncope of 1 months duration.
• Past history of
  – Surgical bypass graft to Lt CCA, Lt brachial artery 6-yrs back.
  – Bypass graft occlusion within 1 yr following surgery.
  – TIA- Rt hemiparesis – 1yr back.
CT scan
Rt VA, CCA intervention

5x18 mm BES at VA. 7X18 mm BES at CCA.

3rd June 2014
Lt SCA, VA intervention

Lt CCA 100%

Lt. SCA 100%

Lt. SCA 7X20 BES, Lt VA 4X38 mm BES Promus EP

13th June 2014
Follow-up course

• 5 yrs clinical f/u - relatively asymptomatic

• 6-mths follow up CT scan:- patent b/l vertebral stents
Thanks
Pulse-less disease of Aortic Arch in Takayasu Aortoarteritis – Percutaneous intervention.

Prof (Dr) Rajesh Vijayvergiya, MD, DM, FSCAI, FACC, FISES
Department of Cardiology
Post Graduate Institute of Medical Education & Research
Chandigarh.
INDIA